CapitalMedicalClinic

Serving Austin since 1934

FINANCIAL AND PRIVACY POLICY ACKNOWLEDGEMENT

Printed Patient Name _____ Date of Birth _____

As a service to our patients, we will file insurance claims to the companies we are contracted with for the services provided. Itemized bills will be provided to you upon request. The filing of insurance does NOT release the patient from responsibility of incurred charges for services provided. All fees including co-pays, deductibles and non-covered services are due and payable on the date of service unless other payment arrangements have been made in advance. We accept Cash, Personal check, MasterCard, Visa, Discover and American Express.

If you have health insurance, you are responsible for:

- Verifying with your insurance carrier that services performed or recommended by our office are covered under your individual plan. We suggest you contact the customer service telephone number listed on your insurance card prior to being seen in our office.
- Knowing what your policy covers. We cannot quote your benefits. Any disputes about payment must be resolved between you and your insurance company.
- Ensuring that authorization is obtained, if required, prior to scheduling any imaging services or specialist visits.

Unless specific payment arrangements have been made in advance, charges for services not covered are due upon receipt. Financial statements are sent monthly. If you are unable to make a payment when due, please contact our billing department at (512) 454-5171 option #7. Account balances that are not paid within 90 days of statement receipt are subject to collections.

If you do not have health insurance**,** payment for all services provided will be required at time of service.

Capital Medical Clinic reserves the right to charge $50.00 for any appointment cancelled without 24hr-advanced notice and there is a $25.00 charge to your account for each returned check.

Assignment and Authorization of Benefits

I hereby authorize payment of insurance benefits to be made directly to Capital Medical Clinic. I understand that I am financially responsible for all charges whether or not they are covered by insurance. In the event of default, I agree to pay all costs of collection and associated attorney fees. I hereby authorize this healthcare provider to release all information necessary to secure payment of benefits. I further agree that a photocopy of this Agreement is as valid as the original.

Acknowledgement of Review of Notice of Privacy Practices

I have been given the opportunity to review this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

Patient Consent to Share Personal Health Information

I hereby authorize Capital Medical Clinic to share my personal health information including financial information with named persons below until further written notice from me:

Name: _____ Relationship to Patient:_____

Name: _____ Relationship to Patient:_____

Authorization for Voicemail Usage for PHI

_____I hereby give permission to leave a detailed message on my voicemail concerning my personal health information.

Authorization to Obtain Prescription Fill History

_____I hereby authorize my physician and clinical team to access my medication fill history. This allows your physician to view medications prescribed by Specialists and other Providers which will assist your physician in reconciling a comprehensive and accurate medication list at your visit. There will be $25 charge for any medication prescriptions requiring a prior authorization. Patients will be notified prior to obtaining prior authorization.

Note: Patients with traditional Medicare will be required to pay $215 at time of Annual Physical since Medicare does not cover an annual physical.

I have read and understand Capital Medical Clinic's financial and privacy policies and I agree to be bound by its terms. I also understand and agree that such terms may be amended by Capital Medical Clinic at any time.

_____ _____

Patient's Signature Date